MEDRX

3250 W. Pleasant Run, Suite 125 Lancaster, TX 75146-1069
Ph 972-825-7231 Fax 972-274-9022

DATE OF REVIEW: 5/23/15

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of Outpatient Occupational Therapy 4/8/15-5/23/15

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒Upheld (Agree)

☐Overturned (Disagree)

☐Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the Outpatient Occupational Therapy 4/8/15 – 5/23/15

PATIENT CLINICAL HISTORY [SUMMARY]:

According to medical records, this worker was injured on xx/xx/xx. The mechanism of injury was not described. Reports in the available medical records indicate that diagnoses included a ganglion of the join, hand and wrist strain and sprain, traumatic arthropathy, neuralgia, neuritis, radiculitis, forearm injury to the radial nerve and tenosynovitis of the wrist and hand.

Records indicate that the worker underwent surgery on January 6, 2015 for a right proximal row carpectomy. She apparently was immobilized following the surgery. The indications for

the surgery were not given in available medical records. Occupational therapy was prescribed on January 21, 2015, two times a week for six weeks.

Clinical note dated March 11, 2015 is an occupational therapy re-evaluation. There was no description of how many therapy sessions had been received. The patient reported 6/10 pain in the wrist and hand and swelling in the hand when the brace which she was wearing was removed. The occupational therapist described severe limitation of motion of the wrist and moderate edema of the right hand. The therapist noted that there had been significant improvement in the thumb and digit movement, but limited improvement in wrist motion. Occupational therapy plans were for electrical stimulation, hot packs, manual therapy and therapeutic exercise two times a week for six weeks.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The information is inadequate to determine the medical necessity of further occupational therapy. The reason for the carpectomy is not elucidated. Diagnoses mentioned do not clearly describe the reason for this aggressive surgery. The postoperative care of the patient was not clearly described and the number of occupational therapy treatments was not clearly described. The post therapy status is described in general terms, but there is no description of physical findings or objective documentation of progress or lack of progress made during the therapy that the injured worker did receive.

ODG treatment guidelines do not specifically address appropriate therapy following capectomy. The guides do address postoperative care for patients with tenosynovitis who have undergone surgery. The recommendation is for 18 visits over 12 weeks. It may be possible that the injured worker underwent the carpectomy for tenosynovitis, but this would seem to be somewhat unlikely and there is no description of contracture and no specific description of the degree of limited range of motion of the wrist in this medical record. If this injured worker has significant limitation of motion or contracture of the wrist, she may indeed need further ocupational therapy, but records presented for review do not provide adequate documentation to determine the medical necessity of continued occupational therapy.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**